26. Personal care services. (continued)

d) up to the amount medical assistance would pay for care provided in a regional treatment center for recipients referred by a regional treatment center preadmission evaluation team; or

e) up to the amount medical assistance would pay for facility care for recipients referred by a preadmission screening team; and

f) a reasonable amount of time for the provision of supervision of personal care services.

- Department prior authorization is also required if more than two reassessments to determine a recipient's need for personal care services are needed during a calendar year.

- Personal care services must be prescribed by a physician. The service plan must be reviewed and revised as medically necessary at least once every 365 days.

- For personal care services

a) effective July 1, 1996, the amount and type of service authorized based upon the assessment and service plan will follow the recipient if the recipient chooses to change providers;

b) effective July 1, 1996, if the recipient's medical need changes, the recipient's provider may request a change in service authorization; and

c) as of July 1, 1998, in order to continue to receive personal care services after the first year, the recipient or the responsible party, in conjunction with the public health nurse, may complete a service update on forms developed by the Department. If a service update is completed, it substitutes for the annual reassessment described in item 6.d.B.

26. Personal care services. (continued)

of this attachment.

- All personal care services must be supervised as described in this item. A reasonable amount of time for the provision of supervision shall be authorized.

- Personal care services are provided for recipients who live in their own home if their own home is not a hospital, nursing facility, intermediate care facility for the mentally retarded (ICF/MR), institution for mental disease, or licensed health care facility.

- Recipients may use approved units of service outside the home when normal life activities take them outside the home and when, without the provision of personal care, their health and safety would be jeopardized. Effective July 1, 1996, total hours for personal care services, whether performed inside or outside a recipient's home, cannot exceed that which is otherwise allowed for personal care services in an in-home setting.

  Effective July 1, 1998, to receive personal care services at school, the recipient or responsible party must provide written authorization in the recipient's care plan identifying the chosen provider and the daily amount of services to be used at school.

- Recipients may receive shared personal care services (shared services), defined as providing personal care services by a personal care assistant to two or three recipients at the same time and in the same setting. For purposes of this item, "setting" means the home or foster care home of one of the recipients, or a child care program in which all recipients served by one personal care assistant are participating, which has state licensure or is operated by a local school district or private school. The provider must offer the recipient or responsible party the

26. Personal care services. (continued)

option of shared services; if accepted, the recipient or responsible party may withdraw participation in shared services at any time.

In addition to the documentation requirements for personal care provider service records in state rule, a personal care provider must meet documentation requirements for shared services and must document the following in the health service record for each recipient sharing services:

a) permission by the recipient or responsible party for the maximum number of shared services hours per week chosen by the recipient;

b) permission by the recipient or responsible party for personal care assistant services provided outside the recipient's home;

c) permission by the recipient or responsible party for others to receive shared services in the recipient's home;

d) revocation by the recipient or responsible party of the shared service authorization, or the shared service to be provided to others in the recipient's home, or the shared services to be provided outside the recipient's home;

e) supervision of the shared personal care assistant services by the qualified professional, including the date, time of day, number of hours spent supervising the provision of share services, whether the supervision was face-to-face or another method of supervision, changes in the recipient's condition, and shared services scheduling issues and recommendations;

26. Personal care services. (continued)

f) documentation by the qualified professional of telephone calls or other discussions with the personal care assistant regarding services being provided to the recipient; and

g) daily documentation of the shared services provided by each identified personal care assistant including:

1) the names of each recipient receiving share services together;

2) the setting for the shared services, including the starting and ending times that the recipient received shared services; and

3) notes by the personal care assistant regarding changes in the recipient's condition, problems that may arise from the sharing of services, scheduling issues, care issues, and other notes as required by the qualified professional.

In order to receive shared services:

a) the recipient or responsible party, in conjunction with the county public health nurse, must determine:

1) whether shared services is an appropriate option based on the individual needs and preferences of the recipient; and

2) the amount of shared services allocated as part of the overall authorization of personal care services;

b) the recipient or responsible party, in conjunction with the supervising qualified professional, must arrange the setting, and grouping of shared services based on the individual needs and preferences of the

26. Personal care services. (continued)

recipients;

c) the recipient or responsible party, and the supervising qualified professional, must consider and document in the recipient's health service record:

1) the additional qualifications needed by the personal care assistant to provide care to several recipients in the same setting;

2) the additional training and supervision needed by the personal care assistant to ensure that the needs of the recipient are appropriately and safely met. The provider must provide on-site supervision by a qualified professional within the first 14 days of shared services, and monthly thereafter;

3) the setting in which the shared services will be provided;

4) the ongoing monitoring and evaluation of the effectiveness and appropriateness of the service and process used to make changes in service or setting; and

5) a contingency plan which accounts for absence of the recipient in a shared services setting due to illness or other circumstances and staffing contingencies.

- The following personal care services are covered under medical assistance as personal care services:

a) bowel and bladder care;

b) skin care to maintain the health of the skin;

26. Personal care services. (continued)

c) repetitive range of motion, muscle strengthening exercises, and other tasks specific to maintaining a recipient's optimal level of function;

d) respiratory assistance;

e) transfers and ambulation;

f) bathing, grooming, and hair washing necessary for personal hygiene;

g) turning and positioning;

h) assistance with furnishing medication that is self-administered;

i) application and maintenance of prosthetics and orthotics;

j) cleaning medical equipment;

k) dressing or undressing;

l) assistance with eating, meal preparation and necessary grocery shopping;

m) accompanying a recipient to obtain medical diagnosis or treatment;

n) effective July 1, 1996, assisting, monitoring, or prompting the recipient to complete the services in items (a) to (m);

o) effective July 1, 1996, redirection, monitoring, and observation that are medically necessary and an integral part of completing the personal care described in items (a) to (n);

p) effective July 1, 1996, redirection and intervention for behavior, including observation and monitoring;

26. Personal care services. (continued)

q) effective July 1, 1996, interventions for seizure disorders, including monitoring and observation if the recipient has had a seizure that requires intervention within the past three months;

r) effective July 1, 1998, tracheostomy suctioning using a clean procedure if the procedure is properly delegated by a registered nurse. Before this procedure may be delegated to a personal care assistant, a registered nurse must determine that the tracheostomy suctioning can be accomplished utilizing a clean, rather than a sterile procedure, and must ensure that the personal care assistant has been taught the proper procedure. A clean procedure is defined as a technique reducing the numbers of microorganisms, or prevents or reduces the transmission of microorganisms from one recipient or place to another. It may be used beginning 14 days after insertion; and

s) incidental household services that are an integral part of a personal care service described in items a) to r).

- The above limitations do not apply to medically necessary personal care services under EPSDT.

- The following services are not covered under medical assistance as personal care services:

a) a health service provided and billed by a provider who is not an enrolled personal care provider;

b) personal care service that is provided by a person who is the recipient's spouse, legal guardian for an adult or child recipient, parent of a recipient under age 18, or the recipient's responsible party;

26. Personal care services. (continued)

c) effective July 1, 1996, services provided by a foster care provider of a recipient who cannot direct his or her own care, unless a county or state case manager visits the recipient as needed, but not less than every six months, to monitor the health and safety of the recipient and to ensure the goals of the care plan are met;

d) services provided by the residential or program license holder in a residence for more than four persons;

e) services that are the responsibility of a residential or program license holder under the terms of a service agreement and administrative rules;

f) sterile procedures;

g) giving of injections of fluids into veins, muscles, or skin;

h) homemaker services that are not an integral part of a personal care service;

i) home maintenance or chore services;

j) personal care services that are the responsibility of the foster care provider;

k) personal care services when the number of foster care residents is greater than four;

l) personal care services when combined with home health services, private duty nursing services, and foster care payments that exceed the total amount that public funds would pay for the recipient's care in a medical institution. This is a utilization control limitation conducted on a case-by-case basis in order to provide the recipient with the most cost-effective, medically appropriate services;

26. Personal care services. (continued)

m) services not specified as covered under medical assistance as personal care services;

n) effective January 1, 1996, assessments by personal care provider organizations or by independently enrolled registered nurses;

o) effective July 1, 1996, services when the responsible party is an employee of, or under contract with, or has any direct or indirect financial relationship with the personal care provider or personal care assistant, unless case management is provided (applies to foster care settings);

p) effective January 1, 1996, personal care services that are not in the service plan;

q) home care services to a recipient who is eligible for Medicare covered home care services (including hospice), if elected by the recipient, or any other insurance held by the recipient;

r) services to other members of the recipient's household;

s) any home care service included in the daily rate of the community-based residential facility where the recipient resides;

t) personal care services that are not ordered by the physician; or

u) services not authorized by the commissioner or the commissioner's designee.

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 5 to this Attachment.

- Not provided.

**SUPPLEMENTARY NOTES**

The following services are not covered under the Medical Assistance program:

1. a health service paid for directly by any other source, including third-party payers and recipients, unless the recipient's eligibility is retroactive and the provider bills the Medical Assistance program for the purpose of repaying the recipient;

2. drugs which are not in the Drug Formulary or which have not received prior authorization;

3. a health service for which the required prior authorization was not obtained;

4. autopsies;

5. missed or canceled appointments;

6. telephone calls or other communications that were not face-to-face between the provider and the recipient;

7. reports required solely for insurance or legal purposes unless requested by the local agency or the Department;

8. an average procedure including cash penalties from recipients, unless provided according to state rules;

9. a health service that does not comply with Minnesota Rules, parts 9505.0170 to 9505.0475

10. separate charges for the preparation of bills;

11. separate charges for mileage for purposes other than medical transportation of a recipient;

12. a health service that is not provided directly to the recipient, unless the service is a covered service;

**SUPPLEMENTARY NOTES (continued)**

13. concurrent care by more than one provider of the same type of provider or health service specialty, for the same diagnosis, without an appropriate medical referral detailing the medical necessity of the concurrent care, if the provider has reason to know concurrent care s being provided. In this event, the Department shall pay the first submitted claim;

14. a health service, other than an emergency health service, provided to a recipient without the knowledge and consent of the recipient or the recipient's legal guardian, or a health service provided without a physician's order when the order is required by state rules, or a health service that is not in the recipient's plan of care;

15. a health service that is not documented in the recipient's health care record or medical record as required by state rules;

16. a health service other than an emergency health service provided to a recipient in a long-term care facility and which is not in the recipient's plan of care or which has not been ordered, in writing, by a physician when an order is required;

17. an abortion that does not comply with 42 CFR §§441.200 to 441.208 or Minnesota Statutes, §256B.0625, subdivision 16;

18. a health service that is of a lower standard of quality than the prevailing community standard of the provider's professional peers. In this event, the provider of service of a lower standard of quality is responsible for bearing the cost of the service;

19. a health service that is only for a vocational purpose or an educational purpose that is not related to a health service;

**SUPPLEMENTARY NOTES (continued)**

20. except for an emergency, more than one consultation by a provider per recipient per day; for purposes of this item, "consultation" means a meeting of two or more physicians to evaluate the nature and progress of disease in a recipient and to establish the diagnosis, prognosis, and therapy;

21. except for an emergency, or as allowed in item 22, more than one office, hospital, long-term care facility, or home visit by the same provider per recipient per day;

22. more than one home visit for a particular type of home health service by a home health agency per recipient per day, except as specified in the recipient's plan of care;

23. record keeping, charting, or documenting a health service related to providing a covered service;

24. services for detoxification which are not medically necessary to treat an emergency;

25. artificial insemination;

26. reversal of voluntary sterilization;

27. surgery primarily for cosmetic purposes;

28. ear piercing; and

29. gender reassignment surgery and other gender reassignment medical procedures, including drug therapy for gender reassignment (unless the recipient began receiving such services before July 1, 1998).

MINNESOTA
**MEDICAL ASSISTANCE**
Federal Fiscal Impact of TN 00-11
Attachments 3.1-A/B, 3.1-E, & 4.19-B: Miscellaneous Services & Rates

1. Recipients with end-stage renal disease (ESRD) may receive hemodialysis in one of four settings: inpatient, outpatient (renal dialysis center), at home, and in a freestanding renal dialysis clinic. Pursuant to 42 CFR §441.40, Federal Financial Participation is available for facility treatment of ESRD if the facility meets the Medicare requirements. The Medicare requirements are found in 42 CFR §§405.2101-.2184, and 42 CFR §405.2102 defines "end-stage renal dialysis facility" to include a renal dialysis center (a hospital unit for inpatient or outpatient needs) and a renal dialysis clinic.

   Minnesota's current Medicaid State plan covers ESRD in all four settings, but does not spell out that a recipient's home or a renal dialysis clinic is an appropriate setting. It also does not clearly state the rate methodology. Therefore:

   - Attachments 3.1-A/B, item 2.a. (Outpatient hospital services) is amended to clarify that outpatient hospital services includes ESRD hemodialysis. Further, it provides that recipients receiving ESRD services in their homes are considered to be receiving outpatient hospital services. This is true because the recipient's hospital will bill the same as if the service was provided in its renal dialysis center.

   - Attachments 3.1-A/B, item 9 (Clinic services) is amended to clarify that ESRD clinics certified by Medicare provide Medicaid clinic services.

   - Attachment 4.19-B, item 2.a. is amended to clarify that ESRD hemodialysis is paid a composite rate (Medicare's "Method I").

   - Attachment 4.19-B, item 9 is amended to clarify that ESRD clinics are paid using the same methodology as item 2.a.

   There is no fiscal impact.

2. Attachment 3.1-E (Standards for coverage of organ transplants) is being updated.

   - The list of covered transplants is deleted so that Attachment 3.1-E need not be amended each time a new procedure is covered or a procedure is covered for a new diagnosis. Attachment 3.1-E is amended to state that procedures and diagnoses approved by the Department and its Advisory Committee on Organ and Tissue Transplants are covered. There is no fiscal impact because this is not a change in policy or procedure.

   - The attachment is amended to require hospitals to be members of, and abide by, the rules and requirements of the Organ Procurement and Transplantation Network (OPTN). Section 1138(a)(1)(B) of the Social Security Act provides that in order to participate in Medicaid, hospitals must be members of, and abide by the rules of the OPTN. See also 42 CFR §482.45(b)(1).

Recently, final rules for the OPTN became effective. Specifically:

1. 42 CFR §121.1(b) provides that in accordance with §1138 of the Act, hospitals in which organ transplants are performed and that participate in Medicaid are subject to 42 CFR Part 121.

2. 42 CFR §121.9(a) requires hospitals to be members of the OPTN and abide by its rules in order to receive organs.

3. 42 CFR §121.10(c)(1) provides that if hospitals do not comply with OPTN rules, they may be terminated from Medicaid transplant participation or receive no Medicaid payment.

There is no fiscal impact.

- The attachment makes clear that organ transplants must be performed in a facility meeting UNOS criteria for that organ transplant, unless the facility is approved by the Department's Advisory Committee on Organ and Tissue Transplants. Currently all facilities eligible to receive Medicare payment meet UNOS criteria, but the committee does have the authority to designate facilities not meeting UNOS criteria pursuant to Minnesota Statutes, section 256B.0629, subdivision 2, clause (4)(ii). There is no fiscal impact.

- The attachment is updated to provide that stem cell and/or bone marrow transplants must be performed in a facility that has been approved by the Department's advisory committee, has been approved by Medicare, or has been accredited by the Foundation for the Accreditation of Hematopoietic Cell Therapy (FAHCT). FAHCT replaces the current requirement that a facility meet American Society of Hematology and Clinical Oncology criteria. The new standard is the accepted community standard for quality assurance purposes. There is no fiscal impact.

- Language governing noncitizens has been clarified to make clear that emergency Medicaid does not include coverage for organ transplants or care and services related to organ transplantation. There is no fiscal impact.

3. Recently, the Health Care Financing Administration discontinued specific HCPC modifiers for nurse practitioners, physician assistant services and advance practice registered nurses (certified nurse practitioners and clinical nurse specialists). The Medicare Program enrolls nurse practitioners, physician assistants and clinical nurse specialists. Minnesota will also enroll these providers. Physician assistants will be enrolled as "treating providers," and their services must be billed by a physician, clinic, or health care facility.

   If enrolled, these practitioners will be paid 90% of the physician rate.

- Attachment 4.19-B, item 5.a. (Physicians' services) is amended to state that physicians' services: (1) provided by separately enrolled physician assistants or clinical nurse specialists will be paid at 90% of the reference file allowable rate, and (2) provided by physician assistants or clinical nurse specialists not separately enrolled will be paid at 65% of the reference file allowable. Note that Attachment 4.19-B, items 6.d.E. (Other practitioners' services; nurse practitioner services) and 23 (certified pediatric or family nurse practitioner services) do not need to be amended.

The Department anticipates the fiscal impact as follows:

| | | FFY '00 | FFY '01 |
|---|---|---|---|
| $17,282 | Federal costs | $ 8703 | |
| | State costs | $ 8203 | $16,531 |
| | TOTAL | $16,906 | $33,183 |

4. The Department will cover anesthesia services provided by anesthesiologist supervising residents and student registered nurse anesthetists. Attachment 4.19-B, item 5.a. (Physicians' services) is amended. The rate methodology follows the Medicare formula and then adds an enhancement to ensure that Medicaid pays an amount that is equal to the payment rate for anesthesiologists directing certified registered nurse anesthetists.

The Department anticipates the fiscal impact as follows:

| | FFY '00 | FFY '01 |
|---|---|---|
| Federal costs | $7,311 | $14,517 |
| State costs | $6,891 | $13,887 |
| TOTAL | $14,202 | $28,404 |

MINNESOTA
**MEDICAL ASSISTANCE**
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Attachments 3.1-A/B, 3.1-E, & 4.19-B: Miscellaneous Services & Rates

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